STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	C 06/27/2024

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/24/24 through 6/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #N0CB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/24/24 through 6/27/24. Event ID# N0CB11. The following intakes were investigated: NC00216975, NC00217049, NC00217331 and NC00218549. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		6/29/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/19/2024

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have advanced directives accurate throughout the medial record for 2 of 3 residents (Resident #47 and Resident #45) reviewed for advanced directives. The findings included: 1. Resident #47 was admitted to the facility on 2/1/23. A review of Resident #47's health directive Medical Orders for Scope of Treatment (MOST) revealed that on 5/13/24 Resident #47 wanted his health directive to change from a Full Code to a Do Not Resuscitate (DNR). The MOST form was signed by Resident #47 on 5/13/24 and in the health directive binder at the nurse's desk.	F 578	A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #47 and Resident #45 did not experience any adverse effects related to inaccurate Advanced Directives in the medical record. The medical record for Resident #47 and Resident #45 were updated to reflect accurate advanced directives on 6/26/2024 by Social Services Director (SSD). B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/26/2024 Nursing Home Administrator (NHA) completed a 100% audit of all residents advanced directives	

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F 578	Continued From page 2 The care plan with a revision date of 5/31/24 stated that Resident #47 health directive was a full code. An intervention was the health directive should be reviewed quarterly and as directed. An interview on 6/26/24 at 11:53 AM was conducted with the Social Services Director. She stated that she reviews health directives at admission, care plan meetings and re-admission from the hospital. The social services director reviews the current code status and if the resident would want to make any changes. If there were any changes to the health directive the social services director updates the care plan. The health directive for Resident #47 should be the same in the medical record, the care plan and health directive binder. In each of these areas the health directive should match. Resident #47's health directive was not matching in the 3 areas. An interview on 6/26/24 at 11:11 AM with the Administrator revealed that the staff are now doing a building wide audit to ensure all health directives are correct. The Administrator stated that a revision was made to Resident #47's health directive and the care plan is now showing he is a DNR. The Administrator stated that there was inconsistency in the health directive for Resident #47. 2. A review of Resident #45's physician orders dated 3/1/24 revealed an order for Do Not Resuscitate (DNR) A review of Resident #45's care plan last revised on 1/2/24 revealed her advanced directive code status as Full Code.	F 578	to ensure electronic medical records reflects the residents Advanced Directives accurately. All residents advanced directives are accurately reflected their medical record. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education was provided to SSD and Minimum Data Set (MDS) Registered Nurse (RN) by the NHA on 6/28/24 to state all advanced directives should be reflected in the medical record accurately. Education was provided to the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Unit Manager (UM) to state any changes in Advanced Directives are to be reviewed in the daily clinical meeting to be updated in the medical record for accuracy. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. An Advanced Directive review audit tool was developed to ensure the medical record accurately reflects the advanced directives for all residents who reside in the building. SSD or designee will utilize the monitoring tool and audit five random resident care plans three times per week for accuracy weekly for twelve weeks, including new admission advance directives. An AdHoc was held on 6/28/2024 to review non compliance and Plan of Correction. The SSD will report the findings of the audits to the Quality Assurance and Performance	

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F 578	Continued From page 3 On 6/27/24 at 9:19 AM the Social Services Director (SSD) stated she was responsible for updating the advanced directive code status care plan for all residents. She stated Resident #45's care plan was not updated when Resident #45's code status was changed from Full Code to Do Not Resuscitate (DNR) on 3/1/24. The SSD stated she normally updated the care plans quarterly and during care plan meetings. Resident #45's quarterly care plan meeting was scheduled to be completed during the current month (June). The Administrator stated on 6/27/24 at 2:04 PM Resident #45's care plan should have been updated to indicate the change in advance directive code status when the code status was changed.	F 578	Improvement (QAPI) committee monthly for 3 months. The QAPI team will evaluate the need for additional monitoring and/or modification of this requirement. Date of compliance: 6/29/2024 The Social Services Director is the individual responsible for compliance with this action plan.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		6/29/24

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F 758	Continued From page 4 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with staff, Hospice Nurse, Medical Director and Consultant Pharmacist, the facility failed to limit the duration of an antipsychotic medication (a drug that affects brain activities associated with mental processes and behaviors) ordered on an as needed (PRN) basis to 14 days and failed to monitor for abnormal involuntary movements on a	F 758	Corrective Action A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/26/2024 an Abnormal Involuntary Movement Scale (AIMS) was completed by the Director of Nursing (DON) on	

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F 758	Continued From page 5 resident receiving an antipsychotic medication (Resident #63) for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #63 was admitted to the facility on 1/22/24 with diagnoses that included major depressive disorder and anxiety disorder. Review of Resident #63's care plan revised 2/23/24 revealed Resident #63 had been care planned for psychotropic/ antipsychotic medication use. The care plan interventions included to monitor effects related to psychotropics. The quarterly Minimum Data Set dated 5/1/24 indicated Resident #63 was cognitively impaired and coded for behaviors that included hallucinations. She had no rejection of care documented and was not coded as receiving antipsychotic medication. a. Review of Resident #63's active physician orders for June 2024 revealed: - An order dated 5/16/24 for Haloperidol (antipsychotic medication) oral tablet 0.5 milligram (mg) give one table by mouth every 6 hours for anxiety/ agitation okay to dissolve in 0.25 milliliters (ml) of water and give sublingual (SL). - An order dated 5/16/24 for Haloperidol oral tablet 0.5 mg give one tablet by mouth every 4 hours as needed (PRN) for anxiety/ agitation okay to dissolve in 0.25 ml of water and give SL. The PRN Haloperidol physician's order did not contain	F 758	Resident #63. On 6/27/2024 Resident #63 received a stop date for PRN Haldol dating 14 past the order date. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/27/2024 all residents with a PRN Psychotropic medications were audited by the Assistant Director of Nursing (ADON) to ensure a stop date and AIMS assessment are in place. All AIMS assessments and PRN psychotropic medications are in compliance. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/28/2024 Nursing Home Administrator (NHA) educated DON and ADON regarding PRN psychotropic medications. Education focused on all residents with a PRN psychotropic medication must have an AIMS Assessment completed and requires a 14 day stop date. On 6/28/2024 Nursing Home Administrator provided education to all Medical Providers including Medical director and Nurse Practitioners providing services at the facility regarding all psychotropic PRN medication must have a stop date within 14 days of the start date of the medication.	

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F 758	Continued From page 6 a stop date for the medication. A review of Resident #63's electronic Medication Administration Record (eMAR) for the months of June 2024 and May 2024 revealed she had not received a PRN dose of Haloperidol. An interview was performed with Nurse #1 on 6/25/24 at 1:16 PM. Nurse #1 stated she thought PRN antipsychotic and psychotropic medications did not need a stop date. She said she thought the PRN orders for antipsychotic medications were indefinite. A telephone interview was performed with the Hospice Nurse on 6/25/24 at 1:25 PM. She stated that Resident #63's Haloperidol had been ordered by hospice. She stated that hospice would add a stop date to PRN antipsychotic medication orders if the facility required a stop date. She said if a PRN antipsychotic had a stop date, at the end of the stop date hospice would re-evaluate the need for the medication and write a new order for the medication if it was still needed. The Hospice Nurse stated she did not recall that the facility had asked for PRN antipsychotic medications to have a stop date. She stated she was the routine Hospice Nurse for the facility and would have been aware if the facility had made a request for stop dates to be included on PRN antipsychotic medication orders. A telephone interview was performed with the Consultant Pharmacist on 6/25/24 at 2:17 PM. She stated that if the PRN was an antipsychotic medication it had to have a stop date of 14 days and then the order would have to be rewritten. She stated that residents who received hospice services were not exempt from needing a 14 day	F 758	On 6/28/2024 all in house nursing staff were educated by ADON focused on all residents with a PRN psychotropic medication must have an AIMS Assessment completed and requires a 14 day stop date. On 6/28/2024 All agency nurses who were working at Randolph Gardens were educated focused on all residents with a PRN psychotropic medication must have an AIMS Assessment completed and requires a 14 day stop date. Any agency nurses not working on 6/28/2024 will be educated prior to the start of their shift focused on all residents with a PRN psychotropic medication must have an AIMS Assessment completed and requires a 14 day stop date. All new RN's, LPN's, starting employment at Randolph Gardens will be educated focused on all residents with a PRN psychotropic medication must have an AIMS Assessment completed and requires a 14 day stop date. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 6/28/2024 Three times per week five rooms will be audited for PRN psychotropic medications to ensure an AIMS assessment is completed and a stop date is in place within 14 days by Director of Nursing / Designee for twelve weeks to ensure medications are not being left at bedside.	

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F 758	Continued From page 7 stop date on PRN antipsychotic medications. She said a pharmacy review with recommendations had been completed for Resident #63 on 6/18/24. The Consultant Pharmacist stated that the recommendations included: Haloperidol should be limited to 14 days and asked for an AIMs assessment to be completed. She stated the Pharmacy recommendations had been sent to the facility on 6/18/24. A review of pharmacy recommendations for Resident #63 was completed. A Pharmacy recommendation dated 6/18/24 read in part - "Physician recommendation: PRN antipsychotics orders are limited to 14-day duration and cannot be renewed unless: 1) the prescriber evaluated the resident for the appropriateness of PRN antipsychotic administration and 2) a new order is generated to extend the PRN antipsychotic beyond 14 days." The pharmacy recommendation had not been completed by the provider. - "Nurse recommendation: Please obtain an abnormal involuntary movement scale (AIMS) and place in the chart to monitor for side effects associated with antipsychotic drug therapy. "The pharmacy recommendation had not yet been completed. A telephone interview was conducted on 6/25/24 at 3:30 PM with the Medical Director. He stated residents receiving hospice did not need a stop date for PRN antipsychotics because they were terminal. He said that if PRN antipsychotic medications had a stop date the medication would fall off the MAR and not be available when needed by the resident for terminal changes.	F 758	On 6/28/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed. Date of compliance: 6/29/2024 The Director of Nursing is the individual responsible for compliance with this action plan.	

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F 758	Continued From page 8	F 758		

b. Review of Resident #63's active physician orders for June 2024 revealed:

- An order dated 5/16/24 for Haloperidol (antipsychotic medication) oral tablet 0.5 milligram (mg) give one table by mouth every 6 hours for anxiety/ agitation okay to dissolve in 0.25 milliliters (ml) of water and give sublingual (SL).

- An order dated 5/16/24 for Haloperidol oral tablet 0.5 mg give one tablet by mouth every 4 hours as needed (PRN) for anxiety/ agitation okay to dissolve in 0.25 ml of water and give SL. The PRN Haloperidol physician's order did not contain a stop date for the medication.

A review of resident #63's electronic medical record revealed an abnormal involuntary movement scale (AIMS) assessment (an assessment used to monitor for a movement disorder that sometimes develops as a side effect of antipsychotic medications) had not been completed for Resident #63.

An interview was conducted with the Director of Nursing (DON) on 6/26/24 at 2:23 PM. She said PRN antipsychotic medications should have a stop date of 14 days. She stated that an AIMS assessment should be completed for residents who received routine and/or PRN antipsychotic medication when the medication was started and then every 3 months. She reviewed Resident #63's medical record and was unable to locate an AIMS assessment. The DON said Resident #63 should have had an AIMS assessment completed when she was started on Haloperidol in May. She said she was unsure why Resident #63 had not

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F 758	Continued From page 9 had an AIMS assessment completed, that it had been missed. She did not say who was responsible for completing the AIMs assessment. The DON stated that she had received the pharmacy recommendations for Resident #63 on 6/18/24. She stated she was working on the recommendations but had not yet completed them. An interview was conducted on 6/27/24 at 2:15 PM with the Administrator. The Administrator said she thought PRN antipsychotic medications had to be reviewed by the physician every 14 days but did not have to have a stop date part of the order. The Administrator stated she did not think residents who received hospice services needed a stop date due to terminal changes. The Administrator said she had been notified by the DON that Resident #63 had not had an AIMS assessment completed. She said Resident #63 should have had an AIMS assessment completed when she was started on the antipsychotic medication.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner (NP), and Pharmacist interviews the facility failed to maintain a medication error rate of less than 5% by having 2 errors out of 27 opportunities which resulted in an	F 759	Corrective Action A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	6/29/24

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F 759	Continued From page 10 7.41% medication error rate. This affected 1 of 3 residents observed for medication administration (Resident # 14). The findings included: Resident #14 was admitted to the facility on 9/3/20. Her medical diagnoses included: hypertension (high blood pressure), history of transient ischemic attacks (mini stroke), cerebral infarction (stroke). Dry eye syndrome of bilateral lacrimal glands. a. A Physician's order dated 8/11/21 read please crush medications and administer in applesauce, every shift for difficulty swallowing. A physician's order dated 8/12/23 read Nifedipine (blood pressure medication) extended release (ER) 24-hour oral 30 milligram (mg) tablet, give one tablet by mouth one time a day for hypertension give with 90 mg tablet to equal total combined daily dose of 120 mg. A Physician's order dated 5/22/24 read please crush medications as appropriate. An observation and interview were made on 6/26/24 at 10:12 AM of Nurse #1 preparing Resident #14's medication. She removed one Nifedipine ER 90 mg tablet and one Nifedipine ER 30 mg tablet from Resident #14's blister card and placed them into the medication cup along with all of Resident #14's other prepared medications. Nurse #1 said Resident #14 wanted her medications crushed due to swallowing difficulty. She then proceeded to place all the medications from the medication cup into the clear plastic pill crushing pouch. Nurse #1 placed	F 759	On 6/28/2024 the Assistant Director of Nursing (ADON) ensured Nurse #1 was provided education informing Nurse #1 Nifedipine ER cannot be crushed. Nurse #1 was educated on where to find the “DO NOT CRUSH” medication list or to call pharmacy for questions regarding crushable medications. On 6/27/2024 Resident #14 received an order to discontinue artificial tears and a new order for Good Sense Lubricating Eye Drops. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/28/2024 all residents with orders for medications to be crushed were audited by the Director of Nursing (DON). All residents with crushed medications have medications in place that can be crushed, or were switched to liquid form, or can be consumed whole as ordered. On 6/28/2024 all residents who have orders for artificial tears were audited by the DON and ADON to ensure the appropriate eye lubrication order is in place. All orders were updated to reflect house eye lubrication. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/28/2024 ADON educated Central Supply Director and Nurse #1 regarding lubrication of eye over the counter orders. Education provided stated to be mindful with eye drop orders, check the order,	

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F 759	Continued From page 11 the pouch containing all of resident #14's medications into the slot of the pill crusher and lifted the handle of the pill crusher to bring it down to crush the medications. Nurse #1 was stopped and asked if all of Resident #14's medications could be crushed. Nurse #1 checked Resident #14's medication administration record (MAR) and then proceeded again to perform the motion of crushing Resident #14's medications. Nurse #1 was stopped again and asked if all the medications could be crushed. She again checked Resident #14's MAR and then proceeded for a third time to perform the motion of crushing Resident #14's medications. Nurse #1 was stopped and asked if Resident #14's ER medications were okay to be crushed. Nurse #1 stated ER medications could not be crushed. She reviewed Resident #14's MAR again and removed the Nifedipine ER 30 mg and 90 mg tablets from the pill crush pouch. Nurse #1 stated extended-release medications could not be crushed because they were supposed to be released slowly for absorption over 24-hours. She said if the ER medication were crushed all the medication would be released all at once. Nurse #1 said she had missed that the Nifedipine was an ER tab. A phone interview was conducted with the Pharmacist on 6/26/24 at 4:42 PM. The Pharmacist stated Nifedipine ER should not be crushed. She said Nifedipine ER was designed to be released over an extended time. The Pharmacist said if Nifedipine ER were crushed the medication would be released all at once. She said the medication being released all at once and Resident #14 not getting a steady release of the medication over 24-hours, could cause blood pressure issues for Resident #14.	F 759	artificial tear orders are not the same as lubricating eye drops. On 6/28/2024 all in house nursing staff were educated by ADON focused on the following: Check if medication can be crushed, look out for do not crush warning on the card or order, any medication that is coated or extended release cannot be crushed. Education provided to all nursing staff to be mindful with eye drop orders, check the order, artificial tear orders are not the same as lubricating eye drops. On 6/28/2024 All agency nurses who were working at Randolph Gardens were educated by ADON focused on the following: Check if medication can be crushed, look out for do not crush warning on the card or order, any medication that is coated or extended release cannot be crushed. Education provided to all nursing staff to be mindful with eye drop orders, check the order, artificial tear orders are not the same as lubricating eye drops. Any agency nurses not working on 6/28/2024 will be educated prior to the start of their shift will be educated focused on the following: Check if medication can be crushed, look out for do not crush warning on the card or order, any medication that is coated or extended release cannot be crushed. Education provided to all nursing staff to be mindful with eye drop orders, check the order, artificial tear orders are not the same as	

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	345134	A. BUILDING _____ B. WING _____	C 06/27/2024

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F 759	Continued From page 12 An interview was conducted with the Director of Nursing (DON) on 6/27/24 at 9:39 AM. The DON said ER medications should not be crushed. The DON said the provider should have been contacted to find an alternative medication that could be crushed. A phone interview was conducted with the NP on 6/27/24 at 1:56 PM. She stated if Nifedipine ER was crushed it could cause Resident #14's blood pressure to drop. She said she was not aware of any blood pressure issues for Resident #14. An interview was conducted with the Administrator on 6/27/24 at 2:08 PM. The Administrator said she had been notified by the DON of the Nifedipine ER medication error today (6/27/24). She said she thought Nurse #1 needed more education on medications that could or could not be crushed. b. A Physician's order dated 8/8/23 read Artificial Tears Ophthalmic solution 0.2-0.2-1% (Glycerin-Hypromellose-polyethylene glycol 400) instill one drop in both eyes three times a day for dry eyes. An observation and interview were made on 6/26/07 at 10:12 AM of Nurse #1 preparing and administering Resident #14's medications. Nurse #1 was unable to locate Resident #14's Artificial Tears on the medication cart. She left the cart to look for Resident #14's Artificial Tears, she returned to the cart with a box of Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) drops. Nurse #1 stated the Lubricating Plus drops were the same as the Artificial Tears ordered for Resident #14. Nurse #1 was observed to administer one drop of	F 759	lubricating eye drops. All new RN's, LPN's, starting employment at Randolph Gardens will be educated focused on the following: Check if medication can be crushed, look out for do not crush warning on the card or order, any medication that is coated or extended release cannot be crushed. Education provided to all nursing staff to be mindful with eye drop orders, check the order, artificial tear orders are not the same as lubricating eye drops. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 6/28/2024 Three times per week three residents will be audited for artificial tears / lubricating eye drops to ensure the orders match the medication provided. Effective 6/28/2024 Three times per week five residents with an order for medications to be crushed be audited for all medications being appropriate to crush for resident or appropriate changes made for medications that cannot be crushed. Effective 6/28/2024 Medication Audits will be completed at random with three nurses or Certified Medication Aides per week for twelve weeks. On 6/28/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed. Date of compliance: 6/29/2024	

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F 759	Continued From page 13 Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) into each of Resident #14's eyes. A telephone interview was conducted on 6/26/24 4:42 PM with the Pharmacist. She said Artificial Tears Ophthalmic solution 0.2-0.2-1% (Glycerin-Hypromellose-polyethylene glycol 400) and Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) were not the same medication. The Pharmacist stated that the medication in the two eye drops were different but served the same purpose of lubricating the eye and would not harm Resident #14. An interview was conducted with the Director of Nursing (DON) on 6/27/24 at 9:39 AM. She said Nurse #1 should have clarified if the eye drops were the same medications. A telephone interview was conducted on 6/27/24 1:56 PM with the NP. She said the Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) drops were a different lubricating eye drop than the Artificial Tears ordered for Resident #14. She said Nurse #1 would need to call her to get an order to use a different eye drop medication than what was ordered. An interview was conducted on 06/27/24 at 2:13 PM with the Administrator. She said she was not aware that the wrong eye drops had been administered to Resident #14. She stated Nurse #1 should have clarified if the Lubricating Plus generic for refresh (Carboxymethylcellulose sodium 0.5 %) was the correct eye drop medication.	F 759	The Director of Nursing is the individual responsible for compliance with this action plan.	
F 760 SS=E	Residents are Free of Significant Med Errors	F 760		6/29/24

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F 760	Continued From page 14 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director, Vascular Physician Assistant (PA), Nurse Practitioner (NP) interviews, the facility failed to prevent a significant medication error when a resident did not receive an antiplatelet medication as ordered. This deficient practice occurred for 1 of 1 resident (Resident #68) reviewed for significant medication errors. The findings included: Resident #68 was re-admitted to the facility on 6/5/24. Her medical diagnoses included: chronic ulcer of left heel, peripheral vascular disease/ severe peripheral arterial disease (decrease blood flow to the lower extremities), cerebral infarction (stroke). A review of Resident #68's hospital discharge summary dated 6/5/24 revealed she was hospitalized from 5/29/24 to 6/5/24 for peripheral arterial disease (PAD) with chronic heel ulcer. She was seen by vascular surgery during her hospitalization and had a drug coated balloon angioplasty (a procedure used to open an artery to re-establish blood flow to tissues) procedure performed on 5/31/24 to her left leg. Her discharge summary included "she will continue Plavix" and that she was "at high risk for left lower extremity limb loss per vascular surgery". Review of the medication orders on the discharge summary revealed under "New Mediations" there	F 760	A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/5/2024 Resident #68 re-admitted to the facility from the hospital on 6/5/2024 with an order to start 75 mg dose of Clopidogrel Bisulfate (PLAVIX). On 6/6/2024 Nurse Practitioner(NP) saw resident for re-admission visit. Re-Visit note from NP states Resident #68 remains on Plavix. The medication list from re-visit note from NP does not have Plavix listed. On 6/21/2024 Novant health Vascular faxed pre-operative note to discontinue Plavix now, Plavix was not re-ordered due to stop date from Dr. Strickland at Novant Health Vascular. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/25/2024 all new admissions and re-admissions from 3/1/2024 through 6/25/2024 were reviewed for potential medication transcription errors by nursing administration team. No other residents were affected by this deficient practice. C. Address what measures will be put into place or systemic changes made to	

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F 760	Continued From page 15 was an order that read: Clopidogrel bisulfate (Plavix) 75 milligrams (mg) tablet, take one tablet (75 mg dose) by mouth daily, start date: 6/5/24; End date: 6/5/25. Review of the quarterly Minimum Data Set (MDS) dated 6/10/24 revealed Resident #68 was cognitively impaired. She was coded for a diabetic foot ulcer. Resident #68 was not coded as receiving an antiplatelet medication. A review of Resident #68's active and inactive physician orders for June 2024 was completed. An order for Plavix was unable to be located. A review of Resident #68's medication administration record (MAR) for June 2024 revealed there was not an order for Plavix on the MAR. An interview was performed with Nurse #2 on 6/25/26 at 3:46 PM. Nurse #2 stated he worked the evening shift on 6/5/24 when Resident #68 was re-admitted to the facility and had entered Resident #68's admission orders into the electronic computer system from her hospital discharge summary. He stated he remembered the Plavix order for Resident #68. Nurse #2 revealed he did not enter the Plavix order into the electronic computer system because when he had looked at the order the start date and stop date for the Plavix order were the same. He explained he had thought the Plavix had been a one-time order she had received at the hospital. Nurse #2 stated he did not see that the start date year and end date year were different. The interview further revealed Nurse #2 did not remember clarifying the Plavix order when he had verified the new admission orders with the	F 760	ensure that the deficient practice will not recur. On 6/25/24 Assistant Director of Nursing (ADON) interviewed Nurse #6, Licensed Practical Nurse (LPN) and other Nurse, LPN who did not transcribe Plavix from physician□s discharge orders into Resident #68□s medical chart. ADON educated Nurse #6 to ensure the orders are thoroughly reviewed, including the year of the end date of the medication. On 6/25/2024 all in house nursing staff were educated on transcribing medications and ensuring end date year for all medications is thoroughly reviewed. On 6/25/2024 All agency nurses who were working at Randolph Gardens were educated on transcribing medications and ensuring end date year for all medications is thoroughly reviewed. Any agency nurses not working on 6/25/2024 will be educated prior to the start of their shift on transcribing medications and ensuring end date year for all medications is thoroughly reviewed. All new RN□s and LPN□s starting employment at Randolph Gardens will be educated on transcribing medications and ensuring end date year for all medications is thoroughly reviewed. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 6/25/2024 Director of Nursing	

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F 760	Continued From page 16 provider. He stated new admission orders were supposed to be checked by two nurses and he was not sure who had checked Resident #68's admission orders after him. An NP progress note dated 6/6/24 included in the note "continues Plavix" "per vascular surgery she is at high risk for left lower extremity limb loss". A telephone interview was performed with the vascular surgery Clinical Supervisor on 6/25/26 at 2:51 PM. She stated Resident #68 had been seen in the office on 6/19/24 for a follow up appointment. She said the provider note from the visit stated Resident #68 had a strong multiphasic (having more than one phase or component) pulse to her left top foot and that she had an active order for Plavix on her medication profile. The Clinical Supervisor stated Resident #68 had an angioplasty procedure completed during her hospitalization and that Plavix was part of the standard protocol after an angioplasty. A telephone interview was performed with the Vascular PA on 6/25/24 at 3:00 PM. The PA stated that Resident #68 had a drug coated balloon angioplasty procedure to her left lower extremity during her hospital stay. She said Resident #68 did not have a stent (a small mesh tube typically used to hold open passages in the body, such as weak or narrowed blood vessels) placed during the procedure. She stated the drug coated balloon procedure was used to open the blood flow to the lower extremity. The PA stated that the blood vessel leading to the top of Resident #68's left foot was the only blood vessel that was able to be successfully opened by the procedure. She said the two blood vessels leading to Resident #68's left heel were unable to	F 760	initiated all new admissions medications will be reviewed by nursing administration team at clinical meeting for accuracy of transcribing medications. On 6/25/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed. Date of Compliance: 6/29/2024 The Director of Nursing is the individual responsible for compliance with this action plan.	

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F 760	Continued From page 17	F 760		

be opened during the angioplasty due to the occlusion being too hard to get the balloon through. The PA stated Resident #68 was supposed to be taking Plavix. She explained during the first 30 days after an angioplasty there was a risk of the blood vessel that had been opened re-occluding, and the Plavix helped to prevent that from happening. She stated when Resident #68 was seen in the office on 6/19/24 for her follow up visit she had a strong signal (pulse) to the top of her left foot, which indicated the blood vessel was still open. The PA explained in Resident #68's case the problem was that she did not have blood flow to the back of her left heel. She stated Resident #68 did not have blood flow to the back of her left heel to begin with because they had not been able to open the blood vessels leading to the back of her left heel during the procedure. The PA stated Resident #68's upcoming left leg amputation was due to the occlusion of the blood vessels leading to her left heel and that not having blood flow to her left heel prevented her wound from healing. The PA stated since Resident #68 never had blood flow to her left heel to begin with, her receiving or not receiving the Plavix would not have had an impact on her needing an amputation of the left leg. The PA stated unfortunately the blood flow re-established to the top of Resident #68's left heel was not enough for her wound to heel. The PA stated that Resident #68's left heel wound would never be able to heel due to the lack of blood flow to the back of her left heel and that was why she needed the amputation.

A telephone interview was performed on 6/25/24 at 9:09 AM with the NP. She stated Resident #68 was scheduled for a left leg amputation on 7/1/24. The NP said she had seen Resident #68

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F 760	Continued From page 18	F 760		

yesterday (6/24/24) and that her left lower extremity was warm and she was able to feel a pedal pulse. The NP stated Plavix was prescribed after the balloon procedure to prevent post-op complications such as blood clots. She stated the presence or lack of presence of the Plavix would not make a significant impact for Resident #68. She stated the Plavix did not prevent the deterioration of the blood vessels. The NP stated the occlusion to Resident #68's left lower extremity was more from atherosclerosis (a buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) not a blood clot. The NP stated Resident #68 should have been started on Plavix when she returned to the facility from the hospital. She stated there was not an indication for it to be discontinued.

A telephone interview was conducted on 6/25/24 at 3:30 PM with the Medical Director. He stated he was unaware that Resident #68 had not received the Plavix that had been ordered on her hospital discharge summary since she had been re-admitted to the facility on 6/5/24. The Medical Director said the Plavix order being missed was a significant medication error.

An interview was performed with the Director of Nursing (DON) on 6/27/24 at 9:45 AM. The DON stated she had been notified by the Administrator on 6/26/24 of the Plavix error for Resident #68. The DON explained the process for new admission orders. She said the nurse would call and verify the new admission orders from the hospital discharge summary with the provider and then enter the orders into the electronic computer system. She stated then another nurse would perform a second order check by comparing the orders that had been entered into the electronic

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F 760	Continued From page 19 computer system against the hospital discharge summary orders. The DON further explained new admission orders were usually verified and entered by the charge nurse and then a floor nurse would perform the second check. She said she was unsure how the Plavix order for Resident #68 had been missed when she was re-admitted to the facility. An interview was performed on 6/27/24 at 2:04 PM with the Administrator. The Administrator stated she had been notified of the Plavix error for Resident #68 by Nurse #2 on 6/25/24. The Administrator said she was unsure how the order for Plavix had been missed.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		6/29/24

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 21 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practitioner (NP) interview the facility failed to wear personal protective equipment (PPE) while providing wound care for a resident requiring Enhanced Barrier Precautions (EBP). This deficit practice occurred for 1 of 3 residents reviewed for EBP (Resident #68). The findings included: Review of the facility's policy and procedure revised on 3/1/2023, entitled "Enhanced Barrier Precautions" read in part: - "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." -"Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities." -"Initiation of EBP- An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO."	F 880	The facility failed to initiate Enhanced Barrier Precautions (EBP) for residents with medical devices and non-chronic wounds such as indwelling catheters and tracheostomies for 1 of 3 residents reviewed with medical devices and wounds (Resident #68). Corrective Action A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/27/2024 The Assistant Director of Nursing (ADON) placed Enhanced Barrier Precautions for Resident #68 related to an open wound. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/27/2024 ADON completed a whole house audit on all residents who require Enhanced Barrier Precautions. No further deficiencies founds with audit. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 6/28/2024 The Administrator conducted an in-service training session with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) relating to the Enhanced Barrier	

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	345134	A. BUILDING _____ B. WING _____	C 06/27/2024

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F 880	Continued From page 22 -"Implementation of EBP- Make gowns and gloves available immediately near or outside of the residents room. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities." -"High-contact resident care activities include- Dressing, Bathing, Transferring, providing hygiene, Changing Linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator, Wound care: any skin opening requiring a dressing." Resident #68 was re-admitted to the facility on 6/5/24. Her medical diagnoses included a chronic ulcer of left heel. An observation was completed on 6/24/26 at 10:36 AM and revealed Resident #68 had a dressing in place to her left foot. The dressing on her left foot had visible seepage of yellow/tan colored drainage on the outside of the dressing. Resident #68 had a pillow on the bed next to her left foot with approximately a 10-inch area of visible yellow/ tan colored drainage on the pillowcase. There were no PPE supplies observed in resident #68's room, in her bathroom, or outside of her door. No signage for EBP was present in Resident #68's room or on the door. An observation was performed on 6/25/23 at 10:00 AM of the Wound Care Nurse performing a dressing change to Resident #68's left foot. The Wound Care Nurse was observed at the foot of Resident #68's bed leaning over the foot board of the bed. The dressing to Resident 68's left foot	F 880	Precaution Policy, noting when a resident is required to have Enhanced Barrier Precautions in place. On 6/28/2024 the Assistant Director of Nursing provided education to all direct care staff including Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), Registered Nurses (RN) and Certified Medication Aides (CMA) related to the Enhanced Barrier Precaution Policy and when it is required to have Enhanced Barrier Precautions in place for a resident. On 6/28/2024 the ADON provided education to all direct care agency staff working at Randolph Gardens including CNAs and LPNs related to the Enhanced Barrier Precaution Policy and when it is required to have Enhanced Barrier Precautions in place for a resident. Any agency staff including CNAs, LPNs, RNs who were not working at Randolph Gardens on 6/28/2024 will be educated related to the Enhanced Barrier Precaution Policy and when it is required to have Enhanced Barrier Precautions in place for a resident prior to the start of their first shift. All CNA, LPN, RN and CMA new hires at Randolph Gardens will be educated at the time of orientation related to the Enhanced Barrier Precaution Policy and when it is required to have Enhanced Barrier Precautions in place for a resident. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 6/28/2024 the ADON or designee will audit five residents who	

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F 880	Continued From page 23 was observed to be unwrapped. The Wound Care Nurse was observed to be holding up Resident #68's left foot and applying a new absorbent dressing pad to the ulcer on her left heel. The Wound Care Nurse was observed to be wearing gloves. The Wound Care Nurse lifted the absorbent dressing pad away from Resident #68's left heel ulcer for the wound to be visualized. The wound covered the surface area of Resident #68's entire heel and was open with areas of necrotic tissue visible. The Wound Care Nurse was not observed to be wearing a gown. An additional observation was completed on 6/26/24 at 9:20 AM of Resident #68's room. There was no PPE equipment present in her room, outside the room, or in the bathroom. No EBP signage was present. A follow up observation was completed on 6/27/24 at 11:16 AM of Resident 68's room. There was no PPE equipment present in her room, outside the room, or in the bathroom. No EBP signage was present. An observation was completed on 6/27/24 at 11:16 AM of the Wound Care Nurse performing wound care to Resident #68's left heel ulcer. The Wound Care Nurse performed hand hygiene and donned gloves and a gown before proceeding to provide wound care to Resident #68's left heel ulcer. There was a PPE cart observed in Resident #68's room and new EBP signage on Resident #68's door. There were no issues noted during the wound care procedure. An interview was conducted on 6/27/24 at 11:32 AM with the Wound Care Nurse. She stated she wore a gown today while performing Resident	F 880	require Enhanced Barrier Precautions three times a week for twelve weeks to ensure the appropriate measures are in place related to the need for Enhanced Barrier Precautions to include the appropriate signage and Personal Protective Equipment (PPE). On 6/28/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Assistant Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed. Date of Compliance: 6/29/2024 The Assistant Director of Nursing is the individual responsible for compliance with this action plan.	

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#68's wound care because she was on EBP. The Wound Care Nurse stated anyone who had a wound was supposed to have EBP in place. She said she was unsure why Resident #68 did not have PPE equipment or a sign on her door for EBP before today. The Wound Care Nurse verbalized Resident #68 did not have EBP in place or PPE equipment in her room on Tuesday (6/25/24) when she performed the wound care to her left heel ulcer. She stated Resident #68 should have had EBP in place due to her wound and that she should have worn gloves and a gown when she performed Resident #68's wound care on 6/25/24.

An interview was conducted on 6/27/24 at 11:57 AM with the Infection Preventionist (IP). The IP stated that residents with wounds and indwelling medical devices should have EBP in place. The IP said staff should use EBP when performing high-contact care activities, using devices, or performing wound care. She stated EBP were not in place for Resident #68 before today because she did not realize she had a wound. The IP stated she did not have a good process for re-admissions needing EBP and it was missed. She stated that Resident #68 should have had EBP in place for her wound. The IP said that the Wound Care Nurse should have worn gloves and a gown when she performed Resident #68's wound care.

An interview was performed with the Director of Nursing (DON) on 6/27/24 at 12:31 PM. The DON stated EBP were needed for residents with indwelling devices and wounds. She said staff should wear gloves and a gown when they were doing direct care with a resident who had EBP in place. She explained direct care would include

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dressing, transferring, bed changes, providing incontinent care, using the device, or changing wound dressings. The DON stated she was not aware Resident #68 did not have EBP in place until today. She said Resident #68 should have been on EBP for her wound. The DON said the Wound Care Nurse should have worn gloves and a gown when performing Resident #68's wound care.

An interview was performed on 6/27/24 at 1:53 PM with the NP. She said she was aware the facility used EBP. She stated EBP applied to residents with indwelling devices and wounds. The NP stated Resident #68 needed EBP and should have had EBP in place for her wound.

An interview was performed on 6/27/24 at 2:18 AM with the Administrator. She stated residents with wounds and devices needed EBP. The Administrator stated EBP should have been in place for Resident #68 due to her wound. She said she was unsure how EBP not being in place for Resident #68 had been missed. The Administrator stated EBP was new and was hard to manage and maintain. She stated the facility needed to come up with a process to manage EBP.